CMH Program Services

_____New
for CSP Year

_____Revision
for CSP Year

INDIVIDUAL SERVICE PLAN

Therapeutic Consultation 97139

Indicate Type: OT /Speech/PT _____ Recreation _____ Psychology _____ Behavior _____ Rehab. Eng._____ Other____

Client _____Medicaid Number_____

Provider Name:_____Provider Number:_____

Start Date: _____ End Date:_____ Quarterly Review Dates:_____ _____ _____ _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME:		
CONSULTATION OBJECTIVES	ACTIVITIES/STRATEGIES	PROJECTED HOURS

Client:_____ TC Service: _____ Start Date:_____

CONSULTATION OBJECTIVES	ACTIVITIES/STRATEGIES	PROJECTED HOURS

Client:_____ TC Service: _____ Start Date:_____

CONSULTATION OBJECTIVES	ACTIVITIES/STRATEGIES	PROJECTED HOURS

**Attach a signature page that includes, at a minimum, the signatures of the client/family caregiver and the consultant.*